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ABSTRACT

This paper provides background information on existing refugee health policy as spelled out in the Refugee Act of 1980, consideration that issues in health and health care have received, and significant program development that has occurred in addressing health care problems. Following the introduction, Section II describes the following: (1) basic U.S. policy concerning the refugee public health system; (2) components of the system (at overseas camps, ports of entry, and local public health facilities); (3) evolution of the system and corrective actions taken since 1979 (screenings overseas and at ports of entry, data collection and information/records transfer, and domestic screening and assessments); and (4) continuing concerns about the system in terms of costs and ramifications for public health in the United States. Section III describes the domestic refugee health system in terms of basic policy, components (initial links to the health care system, follow-up treatment, and funding), and continuing concerns (the timeliness of the delivery of health services, the availability of appropriate services, and the use of the Medicaid financing mechanism and refugee dependency). Conclusions presented in section IV are that in order to address the issue of health care for refugees, there needs to be a better understanding of the problem, clarification of goals, analysis of alternatives, and discussion of the implications of proposed changes.

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THE REFUGEE HEALTH CARE SYSTEM:
A BACKGROUND PAPER ON POLICIES,
PROGRAMS AND CONCERNS

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The RPG produces occasional papers, provides auspices for expert policy analysts and researchers to conduct their work in Washington, D.C., and holds meetings and symposia which bring together program implementors, policy analysts and researchers to discuss refugee program issues of priority concern to policy makers.

RPG

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PROGRAMS AND CONCERNS

November, 1982

This paper is part of an RPG project focusing on the delivery of health care services to refugees. The paper was written by Susan Forbes, with the assistance of Carol Lidsker.

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INTRODUCTION

At the April 1982 Refugee Act Reauthorization hearings, held by the House Subcommittee on Immigration, Refugees and International Law, members and witnesses alike emphasized the importance of examining further the health care system for refugees.

At the hearings, questions focused on three issues: Are newly arriving refugees properly screened in order that the public health is protected? Are the current policies for and administration of medical assistance for refugees contributing to longer term dependency on public assistance than would alternative approaches? Is the refugee program placing undue burdens on local health services, particularly in communities with large numbers of refugees?

The Subcommittee heard testimony from the General Accounting Office (GAO), charging that efforts aimed at protecting public health and alleviating local costs have been inadequate. The GAO witnesses stated that there has been a high incidence of serious diseases among refugees admitted to this country and that this has led to undue burdens on public health services in communities in which refugees have been resettled. They recommended that improvements be made in overseas screening and treatment procedures.

State refugee coordinators and voluntary agency representatives expressed concern about the adequacy of domestic mechanisms for providing medical assistance to refugees. These witnesses argued that programs that link cash and medical assistance have led to overdependence on the welfare system. They also questioned whether refugees are receiving timely, appropriate medical services to promote their self-sufficiency.

Pursuant to these hearings, Congress passed amended language to the Refugee Act pertaining to medical care. The legislation authorized an appropriation of \$14 million for initial medical screenings and treatment for refugees entering the country and instructed the Executive Branch to improve the overseas medical processing of refugees. It is also directed that:

The Director (of ORR) shall study the feasibility and advisability of providing...a mechanism (other than one associated with the provision of cash assistance) through which refugees, requiring medical (but not cash) assistance, are provided medical assistance...and shall report to Congress on the study not later than January 1, 1983.

Clearly, the intention of the House is to focus greater attention on this key issue during the coming months.

Few new concerns were expressed regarding refugee health care at the reauthorization hearings. Since 1975, questions have been asked about refugee health problems and whether the methods of dealing with them are appropriate. This is not to say that criticisms raised about the provision of health care services have gone unanswered. Rather, there has been a variety of efforts to meet one or another weakness identified in the U.S. program. Still, some problems have persisted--in their original or slightly altered form. And, since neither the refugee program nor the circumstances under which it operates are static, there is a need to seek further improvements.

In the past, efforts to resolve refugee health issues have been impeded by a serious lack of accurate information, data and technical expertise. This lack of information and data has impeded monitoring of the program, evaluation of its needs and development of alternatives.

Further, existing policy has not been well-articulated nor is it well-understood. Consensus regarding some of the most fundamental questions

pertaining to refugee health care does not exist. Some of these questions involve highly technical epidemiological issues--What constitutes a public health threat? What types of screening and treatment are appropriate under what circumstances? Others involve more general social and political policy concerns--What is the relationship between refugee use of cash assistance and medical needs? What services are most appropriate for refugees at various points during the resettlement process? Answers to these questions have not come easily.

This paper is a resource document providing background information on existing refugee health policy, the substantial consideration issues in this area have received and the significant program development that has occurred in addressing health care problems. It identifies areas of continuing concern and discusses criticisms of the health program and some of the proposals for change.

THE REFUGEE PUBLIC HEALTH CARE SYSTEM

BASIC U.S. POLICY AND ITS GOALS

The framework for U.S. policy regarding public health concerns is spelled out in the Refugee Act of 1980. This legislation, following practices established in earlier actions permitting the entry of refugees, bars the admission of refugees who would pose a public health threat to the United States. The Act gives discretion to the Attorney General, though, in permitting the entry of refugees with excludable health problems if such action is for humanitarian purposes, assures family unity or is otherwise in the public interest.

The Refugee Act further provides legislative authority for the implementation of a medical screening and care system:

"The Secretary (of the Department of Health and Human Services) in consultation with the (U.S.) Coordinator (for Refugee Affairs), shall:

(A) assure that an adequate number of trained staff are available at the location at which the refugees enter the United States to assure that all necessary medical records are available and in proper order; (B) provide for identification of refugees who have been determined to have medical conditions affecting the public health and requiring treatment; (C) assure that State and local health officials at the resettlement destination within the United States of each refugee are promptly notified of the refugee's arrival and provided with all applicable medical records; and (D) provide for such monitoring of refugees identified under subparagraph (D) as will insure that they receive appropriate and timely treatment.

The Secretary shall develop and implement methods for monitoring and assessing the quality of medical screening and related health services provided to refugees awaiting resettlement in the United States.

The refugee public health system thus is designed to insure that the entry of refugees poses no health threat to the U.S. public, generally by preventing the entry of those with contagious diseases or other ailments believed to have serious public health consequences.

The goal pertaining to the admission of refugees is no different than that governing the entry of all aliens into the United States. The Immigration and Nationality Act specifies the grounds upon which aliens can be excluded from entry. Six classes of aliens are ineligible to receive visas because of the presence of specific medical conditions:

- Aliens who are mentally retarded;
- Aliens who are insane;
- Aliens who have had one or more attacks of insanity;
- Aliens afflicted with psychopathic personality, or sexual deviation, or a mental defect;
- Aliens who are narcotic drug addicts or chronic alcoholics; and
- Aliens who are afflicted with any dangerous contagious disease.

A seventh category specifies that aliens who may constitute a public charge because of an illness are also excludable:

"Aliens not comprehended within any of the foregoing classes who are certified by the examining surgeon as having a physical defect, disease or disability, when determined by the consular or immigration officer to be of such a nature that it may affect the ability of the alien to earn a living, unless the alien affirmatively establishes that he will not have to earn a living."

Although refugees are excludable on these grounds, the provisions of the Refugee Act discussed above permit waivers to be granted under certain circumstances. Given the flexibility in rules governing the entry of refugees with excludable health problems, the aim of the refugee public health system is to channel refugees into the health system in such a way as to ensure that they receive prompt treatment and that their health status is monitored. The federal government assumes responsibility for so protecting the public health.

COMPONENTS OF THE PUBLIC HEALTH SYSTEM

The refugee public health system has established procedures at several levels--in camps and processing centers abroad, at U.S. ports-of-entry and local public health facilities. Ideally, the system works as follows:

Overseas Camps: Prior to final clearance for resettlement in the United States, all refugees undergo a medical screening to determine if they have an excludable condition. These screenings are conducted by the physicians employed by the Intergovernmental Committee for Migration (ICM) under a Department of State contract. The Public Health Service (PHS) monitors quality. During the screening, ICM medical officers look for potentially excludable conditions as described in the Immigration and Nationality Act, or as defined by PHS regulations.

Serious excludable conditions are labeled Class A and include active (or suspected active) tuberculosis, untreated venereal disease, infectious leprosy, mental retardation and certain types of mental illness. A refugee with any of these ailments can be delayed from leaving while treatment is given or permanently prevented from immigrating to U.S. if treatment is not possible. Waivers--on the basis of humanitarian grounds--are available, though, for some Class A conditions. PHS has established guidelines for determining when waivers are appropriate. Refugees with some forms of Class A leprosy are allowed to immigrate, provided they have had six months of treatment, carry special documentation and report immediately to a PHS health facility. Refugees with mental retardation or previous attacks of insanity are allowed to enter the U.S. as soon as an appropriate sponsor or custodian is identified and there is an assurance of care in a medical facility. Less serious conditions including noninfectious tuberculosis are labeled Class B. Individuals with Class B conditions are not excludable.

The examination to determine if a refugee has Class A or Class B illness consists of:

- A brief history of present or previous illness;*
- A visual inspection of the body's skin surface;
- An observation for excludable mental conditions;
- A chest x-ray for tuberculosis for persons 15 years of age or older;
- Chest x-rays for persons under 15 years old if the individual is ill or has a family member with a chest x-ray abnormality;
- A blood test for syphilis for persons 15 years of age or older; and
- A more comprehensive physical examination if excludable conditions are indicated.

The existence of any medical conditions found during the examination, whether excludable or not, is noted on the medical examination form. This form then goes to a consular or immigration officer to determine if the noted condition would prevent the refugee from entering and, if so, whether a waiver of excludability is warranted.

Port-of-Entry: If a refugee is cleared for admission to the United States, he or she next meets the public health system at the port of entry. There, Quarantine Inspectors, employed by Quarantine Division of the Center for Disease Control (CDC), are responsible for determining if there has been any major change in the refugee's condition and whether emergency care is necessary. The process consists mainly of verifying that refugees have the necessary records. Quarantine officers review medical records to check for Class A and some Class B (tuberculosis) conditions; if these are identified, the officers make sure that prior notification is given to local health providers at the refugee's resettlement destination so that necessary preparations can be made.**

Local Public Health Facilities. The third stage in the process of public health care occurs in the resettlement community. All Indochinese refugees are requested to report to a local public health facility

*A recently released GAO report stated that these protocols were not being followed. Their observers noted that no medical histories were taken and the usual examination was quick.

**Concerns have been raised that these quarantine officers are not physicians.

for additional assessment and followup. According to PHS, 80 percent voluntarily report as instructed. CDC also maintains a tracking system to monitor refugees with active tuberculosis, leprosy, mental retardation and previous attacks of insanity. Over 90 percent of these refugees are seen for evaluation within 30 days after arrival.

EVOLUTION OF THE REFUGEE PUBLIC HEALTH PROGRAM

The current system of public health care for refugees, as prescribed in the Refugee Act, evolved over the course of many years as part of the overall immigration health system. Some of the specific components of this system developed during the last few years, though, in response to recommendations made by government and other agencies that have observed conditions in overseas camps and in the United States. Certain issues have reappeared in these reports and form the basis for defining an appropriate public health system for dealing with the needs of the refugee program. These include the need for:

- Continuity of Care. In a system involving a variety of agencies overseas and within the United States, it is important that continuity from one health provider to the next is achieved. Medical problems are identified abroad but must be treated here. To ensure that there is continuity between diagnosis and treatment, there must be a system by which medical records are transmitted and contain sufficient data to permit an accurate assessment of prior care and needed treatment.
- Quality Control. In order for medical personnel at all stages of the public health system to build upon the work of the previous health providers, there needs to be minimum standards of quality determined by a responsible agency and enforced at all stages. The standards apply to accreditation of personnel and duration of medical care procedures to be used in screening for and treating public health problems.
- Flexibility. In the constantly changing environment of the refugee program--in which emergencies often occur and changes in the composition of the refugee population are common--flexibility in meeting health care needs is essential. For example, one set of procedures might be appropriate when camps are overcrowded and the

aim is to move refugees as expeditiously as possible, but another may be more appropriate when the numbers of refugees have diminished or when other programs keep refugees in the camps for extended periods of time.

- Information and Education. The public health system needs to inform health providers about prevalent conditions and effective treatment modes. This type of communication is particularly important since the process of meeting refugee health needs is begun abroad and continued in this country. The special needs of refugees may be unfamiliar to local service deliverers and the U.S. requirements may be unfamiliar to foreign health professionals who work in overseas camps.

Reports

Mid-1979 marked the beginning of a series of studies conducted by the Public Health Service, all of which focussed on ways of improving the capabilities of the public health system to meet the needs of the refugee program. Many of the ideas and suggestions contained in these reports laid the groundwork for subsequent changes in the program aimed at achieving the ends discussed above.

On June 5-7, 1979, a PHS team met with State and local health officials in Seattle, San Francisco and Los Angeles--areas with large numbers of refugees--to discuss refugee health needs. The team concluded that the risk of transmission of diseases from refugees to the U.S. public was low, particularly if adequate screening mechanisms were implemented. They noted that, "...when the existing systems are functioning well, as appears to be the case for a substantial majority of arriving refugees, the risks to the American population are probably lower than those which characterize routine immigration." They also reported that concerns existed among local health officials about the practices followed in processing refugees for admission. These officials noted that the medical screenings received in Southeast Asia were sometimes incomplete and the results inconsistently reported. They also complained that providing health services to refugees was creating a burden on their communities.

The team agreed that the medical screening and system for notifying local health authorities were "clearly less than satisfactory" and recommended a tightening of efforts. They also reported that there was a need for better coordination among the four groups most responsible for dealing with refugee

health problems on arrival--the voluntary agencies, local health departments, other providers of health services including PHS facilities and the Indochinese community itself. They further recommended that additional federal funds be allocated for translators, outreach services and education regarding refugee needs and U.S. health concerns.*

Immediately following receipt of this report, HEW dispatched a team to review the medical screening process overseas. A major concern raised by this group pertained to the process through which waivers of excludable conditions were obtained. At the time, there were large backlogs of refugees waiting in camp because one member of their family was awaiting medical clearance. CDC felt that the backlog was causing as many health problems as the exclusions were meant to solve. They recommended that the waiver process be expedited by allowing refugees with active but not seriously communicable diseases to enter the U.S. and then be treated. The Surgeon General concluded that "suspension of excludability for active (noninfectious) tuberculosis, mental retardation, previous attitudes of insanity and infectious leprosy would contribute positively to the health and welfare of refugees without endangering the health of the American people."

Later in the year, PHS submitted another report--based on the findings of the Principal Regional Officials in five regions--on the health impact of Indochinese refugees in areas with large concentrations of these persons. In findings similar to the other studies (and the results of an earlier trip to Hawaii), the report concluded that refugees posed no public health threat. It did note that the transfer of information from overseas camps to local providers was faulty. Refugees often arrived without medical documents and when they did have documents, the information was sometimes questionable. The report cited some actions to address this problem:

*U.S. Department of Health, Education and Welfare, Public Health Service, "Report of the USPHS Team to Assess the Health of Indochinese Refugees on the West Coast," June 14, 1979.

- "● First, CDC has taken steps to tighten up the overseas screening program to assure that the information contained on the [report form] OF-157 is complete and accurate.
- Second, if the refugee arrives with a Class A excludable condition, the CDC Quarantine Officer calls local health department personnel at the refugee's indicated destination to apprise them of the situation.
- Third, the CDC Quarantine Office forwards copies of the OF-157 to the local health department in the refugee's indicated resettlement area."
- Fourth, the introductory letter provided to the refugee and his/her sponsor (discussed above) urges that the X-ray, the OF-157, and any other medical information be safeguarded and brought to the local health department or medical provider in the resettlement area at the time of the medical examination."

The report left open the question of the need for screening programs in the U.S., noting that "tracking of (refugees) who do gain access to the medical care system will, over time, provide a more accurate assessment of the need for more comprehensive domestic screening." In the meantime, it was likely that local health departments would implement their own procedures for assessing the health status of refugees, particularly since these agencies were responsible for ensuring that refugees receive follow-up treatment for public health conditions. The report pointed out that not all states permitted the funding of health assessments through Medicaid funds, and recommended that steps be taken to identify and fill funding gaps.*

Corrective Actions

Following these reports, HHS implemented a number of actions designed to correct deficiencies in the refugee public health system.**

*U.S. Department of Health, Education and Welfare, Public Health Services, "Report to the Secretary-Indochinese Refugee Impact on Health Care Services," September 4, 1979.

**For more detailed description, see Department of Health and Human Services, Refugee Resettlement program, Report to the Congress, FY 1979, FY 1980 and FY 1981.

The Office of Refugee Health Affairs was established within PHS' Office of International Health, initially in response to the emergency in Cambodia, but then to coordinate the activities of PHS agencies in developing these new programs.

Screenings: Overseas and at Ports-of-Entry.

- In 1979, CDC assigned personnel to oversee the overseas medical screening procedures used by ICM and to upgrade x-ray interpretation and tuberculosis laboratory diagnostic testing to meet CDC standards. Additional personnel were also assigned to ports-of-entry to inspect and review the records of new arrivals.
- In 1979, CDC conducted health assessments of 4,446 refugees arriving at West Coast ports-of-entry to help determine if previous screenings were adequate. They found few signs of acute health conditions requiring further medical care of major public health problems. They did identify a range of personal health problems requiring treatment.
- In 1980, to expedite the flow of refugees, CDC implemented changes in policy and procedures both overseas and in the U.S. concerning the admissibility of Class A "excludable conditions" during the "suspension of excludability" ordered by the Attorney General.
- In 1980, a comprehensive immunization program against childhood diseases was begun. Immunization records were prepared so that refugees could inform local health officials.

Data Collection and Information/Records Transfer.

- In 1979, CDC's Morbidity and Mortality Weekly Report began a series of articles on Indochinese refugee health problems. These publications are circulated to more than 90,000 private physicians and State and local health departments.
- In 1980, CDC established a new system for collecting and disseminating copies of refugee screening forms and immunization records. To accomplish this, mini-computers were installed at the four West Coast ports-of-entry and in New York. Information is kept in computers at CDC headquarters regarding refugees who enter elsewhere. Reports that were previously hand-tabulated were computerized.
- In March, 1980, demographic and arrival information on refugees was transferred to the CDC computer facilities.
- In May, 1980, a computer capacity to identify and track refugees with tuberculosis was established. Follow-up reports on refugees referred to health departments were entered into the computer system.

- In 1981, the CDC data base on Southeast Asian refugee arrivals had become so useful that it became the primary source of arrival and destination statistics for the Office of Refugee Resettlement.
- In 1981, an optional health notification system, known as 'point notification' was implemented to promote centralization of records. Under the system, all forms are sent to a single agency in the State --generally the State health department--to then be forwarded to local health departments.
- In 1981, CDC, in cooperation with national resettlement agencies, developed an information network that permits health departments to locate the initial resettlement location of a secondary migrant. Then, the local health officials can request the forwarding of records that went to the original place of residence.

Domestic Screenings and Assessments.

- In 1979, PHS Hospitals and Outpatient Clinics were instructed to assist State and local health departments and voluntary agencies in the provision of health services to refugees. The Public Health Hospital in San Francisco entered into a contract with the Indochinese Health Intervention Program to provide outreach, translator and other services to refugees.*
- In late 1979 and 1980, several States implemented a 1975 Action Transmittal (SRS-AT-75-27) to purchase screening and assessment services for refugees. According to the AT, these services are reimbursable by ORR: "Where additional services are required and where such services would be available to displace U.S. citizens through public facilities, the State may purchase services for refugees from such facilities in order to avoid the refugee's becoming a burden on publicly-funded local facilities."
- In 1980, ORR established a new health assessment program, providing support to State and local health agencies through a \$4.8 million interagency agreement with CDC. These funds were awarded through a grant process by the Regional Health Administrators on the basis of the extent of local refugee health problems and the need for assistance to address these problems. The purposes of the health assessment program were 1) to address unmet public health needs associated with refugees and 2) identify health problems which might affect employability and refer such refugees to appropriate services.**

*With the closing of the PHS hospitals and outpatient clinics at the end of FY 1981, the San Francisco PHS refugee health program transferred its refugee operations to the City of San Francisco Health Department.

**This program, as it relates to its second purpose, is discussed in the next chapter.

(By 1981, of all Southeast Asian refugees who arrived in areas with operating health assessment programs, 80.2 percent were receiving assessments. In areas in which the grant funds had permitted the development of a more coordinated program, 92.7 percent of the refugees were being contacted and 90 percent were receiving assessments.)

- In 1981, CDC instituted a program to help recipients of its grants, by collecting and circulating information and translated materials.

CONTINUING CONCERNS ABOUT REFUGEE PUBLIC HEALTH ISSUES

Despite the substantial program development in the area of refugee public health, there is still concern about two specific issues: the effects of the refugee program screening procedures on the public health and its impact on domestic health costs.

Ramifications for the U.S. Public Health

The General Accounting Office (GAO), in its recent report on overseas processes,* labeled medical screening procedures abroad as "cursory" and medical processing procedures at ports-of-entry as insufficient. The authors criticized medical techniques that were used to identify the presence of diseases, argued that records compiled by UNHCR medical personnel were not used in the screening,** and noted that the screening was not designed to pick up certain diseases, such as parasitic ones, that were common among Southeast Asians. Moreover, GAO reported that information on a refugee's medical condition was not provided in a timely enough fashion to be factored into INS' decision making on the eligibility of a refugee for admission to the U.S.

The report concluded that "...the medical screening of Indochinese refugees may not be adequate to protect the spread of serious, contagious diseases to the American people."

*U.S. General Accounting Office, Improved Overseas Medical Examination and Treatment Can Reduce Serious Diseases in Indochinese Refugees Entering the United States, August 5, 1982.

**The Department of State and HHS entered negotiations with UNHCR to gain access to these records.

In support of these contentions, GAO cited higher incidences of tuberculosis, parasitic diseases, malaria, hepatitis and leprosy in refugees than in other U.S. residents. In recent testimony, before the House Subcommittee on Immigration, Refugees and International Law, GAO repeated these concerns, adding recommendations that new treatment programs be implemented abroad and that no refugee with an excludable disease be admitted to the U.S. until his or her treatment program is completed.

The Public Health Service has not concurred with the general findings of GAO regarding the public health threat posed by refugees. In response to an August 1981 inquiry from GAO, PHS wrote:

Millions of aliens have entered the United States, from Asia, and many from other parts of the world with health conditions like those in Asia. Admissions of these aliens in accordance with U.S. laws and regulations has not resulted in consequently adverse effects on public health in America. The great majority of these aliens require no medical examination to enter the United States legally. We expected Indochinese refugees to have health problems similar to those of other aliens admitted from Asia. In general, these are personal health problems and of minimal public health importance.

Regarding GAO's data on the incidence of disease in refugees, PHS noted that "the recurrence of certain disease in refugees does not necessarily mean that those diseases will occur in other persons and be attributable to refugees." PHS concluded that the policies for medical examination and treatment of refugees in Asia are "appropriate and consistent with modern concepts of epidemiology, disease control, and disease prevention. These policies and procedures will continue to protect effectively the health of refugees and safeguard the health of the American public."

Regarding the specific tests used to identify refugee health problems, PHS explained that the screening focused on identifying conditions that could result in exclusion. The purpose of the examinations was not to provide comprehensive evaluation of a given refugee's health status, but to determine

if he or she had an excludable illness. PHS has argued that the tests used by ICM during the screenings are appropriate, to the extent that they are accurately implemented, to fulfill the statutory and regulatory requirements and to protect the U.S. public health.*

Weaknesses have been identified, in the implementation of the public health system. In a recent study, Kaleidoscope, researchers heard criticisms that health data did not always reach the appropriate public health office, that the refugees still carried forms with incomplete information, and that overseas screenings sometimes missed serious diseases. These observations led the authors to recommend that more careful attention be paid to monitoring the overseas screenings.

Many of the procedures that are now under attack were implemented in 1979 and 1980 in response to tremendous pressures to expedite the flow of refugees. During that period, the flow of refugees out of Vietnam, Cambodia and Laos was very high; camps were overcrowded, and a number of the first asylum countries were threatening to expel any refugees who crossed their borders. In response to these pressures, the United States agreed to accept 14,000 refugees per month. The movement of these persons was slowed down, however, by required detainment of excludable refugees and voluntary delays on the part of other refugees who were unwilling to travel without detained family members.

*GAO has noted that ICM has implemented more rigorous mechanisms in assessing the health status of refugees going to countries, such as Canada and France, that have more stringent requirements than the U.S.'s. The GAO study did not indicate, however, if statistics on the incidence of disease in refugees living in these countries differ substantially from U.S. statistics. A recent Canadian study shows little difference in these rates.

There were also concerns that crowded conditions and poor sanitation were conducive to the further spread of disease and that it was in the public health interest to expedite the flow of refugees out of the camps. The decision was made to permit the entry of refugees with active diseases if they were not highly contagious and could be treated in the United States.

During the past year, as the admissions levels of refugees have declined, perceptions about expeditious flows have changed. Rather than try to move refugees as quickly as possible, regardless of the individual refugee's circumstances, it is now believed preferable to provide U.S.-bound refugees with English language training and orientation before they come here. These programs are designed to help prepare refugees for life in the United States. As a side effect, they provide a four-month period during which refugees who have been approved for resettlement can have their health needs addressed. PHS, the voluntary agencies and the Department of State are all looking into the possibilities of implementing new health programs in the processing centers.

PHS warns, though, that conditions in Southeast Asian camps still limit the ability of health care providers to deliver comprehensive diagnostic services or treatment to refugees. For example, camp refugees can easily re-acquire parasitic diseases after undergoing extensive treatment because of inadequate hygienic conditions.

Impact on Domestic Health Resources and Facilities

A second issue raised by GAO regarding the refugee public health system is the extent to which current overseas procedures have caused undue burdens on domestic health facilities. In testimony before the House Subcommittee on Immigration, Refugees and International Law and its recently released study, GAO staff reported that local health departments have had to absorb the additional costs of providing refugees with services not covered by the

federal refugee program. They cited Fairfax County, Virginia, as one location with mounting costs that could be attributed to meeting refugee public health needs. According to GAO, from August 1979 to April 1981, Fairfax spent about \$270,000 to provide refugees initial health screening; blood, parasite, and tuberculosis tests; and immunization. Only about \$61,000 was reimbursed through the refugee health program. Los Angeles and Orange Counties, California and the District of Columbia, among other locations with large numbers of refugees, have had similar problems, they added.

GAO argues that the domestic refugee health costs could be reduced substantially if refugees are diagnosed and treated overseas. According to GAO's report, "performing a thorough and reliable examination overseas with proper documentation in refugees' medical records should reduce the need for health departments to routinely examine refugees upon arrival." Also, the report notes that refugees receiving treatment abroad would be likely to need less medical care after arriving in this country.

PHS questions whether increased treatment overseas will reduce domestic costs. In comments on GAO's draft report, that reflect commonly voiced perceptions, PHS stated: "The capacity to accomplish technically reliable, comprehensive diagnosis and treatment for large numbers of refugees (equivalent to that which is available in the U.S.) does not exist in Southeast Asia." The agency further argued that the domestic costs noted by GAO are not necessarily related to public health concerns. According to PHS, "refugees will continue to require general medical and dental care, prenatal care, maternal and child health services, surgical procedures, and all the other routine, personal health and preventive health services that U.S. residents require."

PHS cited the improvements that have been made in providing federal funds for health assessments. Recognizing that local health departments have incurred costs in screening and assessing incoming refugees, the federal government established a special program and appropriated \$4.9 million to provide health assessment grants to states and localities. The federal government has also reimbursed six states that have invoked a provision in SRS AT-75-27 that permits states to enter into federally-reimbursable contracts with health facilities that provide services to destitute U.S. residents. For the most part, these contracts have paid for screening and diagnostic services for refugees.

Where high costs are associated with public health screening and treatment, these are, to some extent, attributable to local decisions to implement rigorous screening and treatment policies. Although PHS recommends that refugees be examined for a range of diseases (tuberculosis, parasites, hepatitis B, and malaria), communities are free to select the level and form of services they provide. Many local health providers, suspicious of the quality of overseas medical examinations, repeat procedures--already administered and recorded on camp medical records--rather than rely on the medical procedures performed abroad. Although this tendency has, of course, been reinforced by inadequacies in record development and forwarding, duplication of tests by health providers is not uncommon, even in the best domestic circumstances.

THE DOMESTIC REFUGEE HEALTH SYSTEM: DEALING WITH HEALTH
PROBLEMS THAT IMPEDE SELF-SUFFICIENCY

BASIC U.S. POLICY AND ITS GOALS

As with public health issues, it is the Refugee Act of 1980 that provides the framework for U.S. policy regarding the delivery of medical services to refugees. Title III of the Act provides authorization for the delivery of services that will enable refugees to achieve self-sufficiency. Three sections deal explicitly with health services. First, "the Director (of the Office of Refugee Resettlement) is authorized to make grants to, and contracts with, public or private nonprofit agencies for up to 100 per centum of the ... medical assistance provided to any refugee during the thirty-six month period beginning with the first month in which such refugee has entered the United States..."

Believing that some refugees, in need of health services, would not qualify for assistance as specified above, the Refugee Act further included a provision designed to encourage federal flexibility:

The Director is authorized to allow for the provision of medical assistance...to any refugee, during the one-year period after entry, who does not qualify for assistance under a State plan approved under title XIX of the Social Security Act on account of any resources or income requirement of such plan, but only if the Director determines that

- (A) This will (i) encourage economic self-sufficiency, or (ii) avoid a significant burden on State and local governments; and
- (B) the refugee meets such alternative financial resources and income requirements as the Director shall establish.

The Conference Report on the Refugee Act made clear the intention of Congress--through such provisions--to provide sufficient flexibility to respond to different health problems and needs of the various refugee groups resettled in the U.S.

The language of the provision permitting special one-year eligibility for health services indicates the twin goals of the domestic refugee health system--

- to encourage economic self-sufficiency and
- to avoid a significant burden on State and local governments.

Regarding the first goal, the Refugee Act recognized that refugees, as a group, have undergone unique experiences that affect their health in ways that can impede rapid adjustment to a new life. Development of the Refugee Act was informed, in particular, by the entry into the United States of large numbers of Indochinese refugees. Many of these individuals had fled their homelands in small boats or by foot; had suffered exposure to the elements and attack by pirates on their journeys; had experienced long periods of famine; and had languished in refugee camps for many months, if not years, before resettlement. Given the nature of their experiences, it was assumed by U.S. authorities that refugees would contract health and mental problems that would have lasting ramifications. And, all evidence from refugee camps of 1979 and 1980 indicated that many of these concerns were justified. Refugees did suffer from malnutrition, parasitic diseases and other debilitating illnesses that can affect an individual's capacity to be self-supportive in a new environment. Thus, to ensure that refugees with such health problems received appropriate care, the Refugee Act authorized medical assistance programs and encouraged governmental flexibility.

Regarding the second goal, the intent of the health related provisions of the Refugee Act was to permit refugees to receive such services in a manner that would avoid undue burdens on State and local resources. A major premise of the Refugee Act is the federal government's responsibility for providing financial reimbursements for special refugee assistance.

Thus, the Refugee Act authorized 100 per cent reimbursement of medical assistance costs (for up to 36 months) and included a provision for permitting medical assistance to refugees not eligible for Medicaid if such assistance would avoid a significant burden on State and local governments.

COMPONENTS OF THE DOMESTIC REFUGEE HEALTH CARE SYSTEM

Certain key factors define the characteristics of an appropriate domestic delivery system. These include:

- Flexibility. Since refugees are not a homogenous group, their health needs differ. A good health care system will be flexible enough to deal with a variety of health statuses and medical needs.
- Timeliness. Refugees often enter with pre-existing public and personal health problems that must be addressed in a timely fashion, with a minimum of delays.
- Cultural Appropriateness. Refugees often come from societies with concepts about health care that differ from U.S. standards. They need to be educated about U.S. practices and U.S. health providers need to be educated about their needs and beliefs.
- Accessibility. For a newly arrived refugee, in particular, transportation to a health facility, help in making an appointment and the availability of translators are important factors in ensuring accessibility to care.

In discussing the components of the domestic health program, two points should be kept in mind. First, most of the program development in this area has focused on ways to facilitate the entry of refugees into the health care system. Second, there has been relatively little program development in devising alternatives for funding follow-up treatment. A discussion of the current federal programs and examples of some federally funded State and local initiatives follows.

Initial Links To The Health Care System

Voluntary resettlement agencies have the initial responsibility for introducing refugees to the health care system. Under a cooperative agreement

with the Department of State to provide a range of reception and placement services, the voluntary agencies have agreed to:

"encourage and assist the refugees as soon as possible after arrival to seek health services available through the local health system (public or private) and assist refugees with known health problems to secure follow-up treatment as necessary."

It is believed necessary to introduce refugees to the health care system--rather than assume that they will seek treatment if that proves necessary--for a variety of reasons. First, many refugees, particularly those from Indochina, enter the country with some number of illnesses requiring treatment. Parasitic diseases are most common. Although these illnesses do not generally constitute a public health threat, they are personal problems that can be debilitating. Second, many refugees, again particularly from Indochina, are (in the words of a federal health official) "medically illiterate" as far as U.S. standards and practices are concerned. Moreover, often they do not recognize the symptoms of many diseases and therefore do not seek treatment, even when it is called for by U.S. standards.

Several public services are (or have been) available to assist the resettlement agencies in linking refugees to the health care system. Some of these programs also have public health components, as described in the previous section. For example, until they were closed in FY 1982, the PHS hospitals and clinics were instrumental in providing assessments of refugee health care needs. For example, in FY 1980, the San Francisco hospital had 8,511 refugee patient visits between October and April. Between October 1980 and July 1981, this facility had 13,838 visits of refugees. The PHS hospitals provided tests for a variety of illnesses -- having both public and personal health ramifications -- and referred refugees for treatment, when necessary.

Further support is provided through an ORR-financed/PHS-administered program in which grants are made to State and local health agencies to help them identify refugees with health problems which might affect employability and refer such refugees to appropriate services.* Small grants, averaging \$36,000 in FY 1982, are awarded to State agencies to help monitor refugee health conditions and coordinate service provision. Funds have covered, among others, the costs of hiring refugee health service staff, providing laboratory services, and translating medical forms.

In six States, the domestic health assessment program is supplemented by implementation of SRS-ST-75-67 through which States can purchase services--for refugees who are needy--as long as such services are provided to other destitute populations. These States have used ORR funds to purchase health assessments for refugees entering their areas. Although originating in some States from a concern with protecting the public health, these programs serve a second purpose (considered to be equally or more important by many proponents) of bringing newly arrived refugees into contact with the health care system. In Illinois, for example, providers are required to perform the following services:

coordinate the delivery of health and health-related services to refugees in its service area through: joint planning of clinics and other services with providers in the area; the establishment or revision of referral agreements with these providers, to include outreach, follow-up and the exchange of service delivery documentation as the provider's needs and the other area providers' capabilities dictate; making appointments when necessary for refugees in need of care; making data available as needed by referral agencies and providers to enhance the delivery of effective services needed by refugee(s) involved; and arranging for... services. (emphasis added)

*This program and the one described below also have a public health component, as described in the preceeding section.

According to information provided by the Illinois program, its aim is also to provide health personnel with treatment information for tropical medical conditions and heighten the transcultural awareness of health care providers to assure thorough medical examinations and successful treatment. Thus, the purpose of the program is to link refugees to a health care system and to provide information that will make that system as appropriate to their needs as possible.

A similar end has been sought through the use of Title XX support services. These services are designed to help refugees overcome some of the cultural, linguistic and logistic barriers to obtaining effective health care. They include: information and referral to appropriate sources of medical care; outreach services; translator/interpreter services and some mental health/adjustment services. Currently, States determine the range of social services to be provided and enter into purchase of service contracts with providers.

The funding of health-related services varies greatly by State and region, particularly since recent directives from ORR that priority be given to employment services and language training. Region V, in which some of the most extensive funding of health-related support services has taken place, can serve as an illustration. In FY 1981, Illinois issued eight contracts for these services, amounting to \$180,318; Minnesota gave 10 contracts, amounting to \$1,387,493, and Wisconsin signed 15 contracts, amounting to \$325,017. On the other hand, Michigan used no FY 1981 funds to purchase health-related social services and Ohio provided support of these services only as part of much broader programs that also offered language training and employment services.

It is not uncommon for refugees to be introduced to the U.S. health care system through a combination of programs financed through a variety of means.

San Francisco provides an example. In 1979, the PHS hospital there entered into an agreement with Catholic Charities through its Indochinese Health Intervention Program (IHIP). Catholic Charities is a voluntary agency responsible for reception and placement of refugees and also receives funding through the State's purchase of service Title XX contracts for providing health-related service. IHIP acts as an intermediary by assisting refugees in gaining access to health services and facilitating their use of these services thereafter. The services provided by IHIP include:

- o Outreach through voluntary and community agencies;
- o Transportation of refugees to the health screening;
- o Providing multi-lingual, multi-cultural translators and translations of health education materials;
- o Scheduling appointments for the screenings; and
- o Coordinating follow-up with sponsoring voluntary agencies.

Since the closing of the San Francisco PHS hospital at the end of FY 1981, the Catholic Charities program (renamed the San Francisco Refugee Health Agency and serving Ethiopians and Poles as well as Indochinese) has been working with the City of San Francisco Health Department to continue to provide these services.

Follow-up Treatment

Should the initial health assessment reveal health problems that are in need of treatment, what follow-up services can be obtained for the refugee? These services can be provided through a variety of mechanisms, involving either public or private health service deliverers and using either public or private funding.

Service Providers

As far as the health providers are concerned, refugees can be referred to the following resources:

- Private physicians
- Community Health Centers and Community Mental Health Centers;
- Health Maintenance Organizations; and
- Clinics and emergency rooms, in public and private hospitals.

The capacity of these service providers to meet the needs of refugees differs greatly. In some cases, the institutions themselves provide culturally sensitive, multi-lingual health services through professionals who are aware of refugee health needs and have the ability to communicate with patients. At the other extreme, are health providers who have had no previous exposure to refugees or to their health problems. Access to translators and information about refugees is extremely important in these cases.

Funding

By and large, funding for follow-up treatment for refugees comes through one of two mechanisms -- both State-administered: the Title XIX Medicaid and Medically-needy program (for refugees who meet all State eligibility requirements)*, or the Refugee Medical Assistance (RMA) program (for refugees who meet State income eligibility but not family composition requirements)**. Waivers of the family composition requirements for medical assistance are available to refugees during their first eighteen months in the country. Thereafter they must qualify for assistance on the same basis as other indigent persons in the State.

During a Medicaid-eligible refugee's first thirty-six months in the United States, ORR pays the normal State share of that individual's Medicaid

*In most States, eligibility for Medicaid is tied to eligibility for income assistance (AFDC, SSI) programs. In some States, though, the Medically-Needy can be provided medical assistance if their medical expenses lower their income level to that of the AFDC-eligible. A few states do not require individuals to sign up for cash assistance in order to receive Medicaid.

**Single persons, childless couples and intact families are not generally eligible for Medicaid.

expenses and the Health Care Financing Administration (HCFA) pays the normal federal share of the program. For non-Medicaid eligible refugees, ORR pays the entire cost of the program during the first eighteen months. During the second eighteen months States can be reimbursed only if assistance is provided under a general assistance program available to other residents.

The use of the Medicaid/RMA mechanism for providing medical coverage to refugees dates from the Cuban program of the 1960's and early 1970's. When Indochinese refugees began to be resettled here in 1975, continued use of this system was thought to be advantageous for several reasons: First, the system is tailored to meet the health care needs of low income and minority groups. It is designed to provide basic coverage of certain services and has the flexibility to permit States to offer optional ones, if desired. Second, the system was already in place and could provide coverage to large numbers of refugees with no start-up time or costs. States had developed eligibility requirements, had relatively accessible welfare offices where eligibility determinations could be made; and had means through which the program could be administered. Finally, use of Medicaid seemed to be the best way to balance the special needs of refugees for health care and society's desire for an equitable system in which no groups receive preferential treatment.

Medicaid and RMA generally operate through a fee-for-service reimbursement mechanism. Refugees receive services from a health care provider who then submits a bill for these services to the Medicaid office. Based on rates established for certain procedures performed in certain areas, Medicaid pays the provider what is considered a fair price for services. Not all services are reimbursable in all States. Mandatory services include:

- inpatient hospital services
- outpatient hospital services
- laboratory, X-ray services
- skilled nursing facilities for individuals age 21 and older
- rural health clinics
- home health care
- physician services
- family planning
- EPSDT for those under the age of 21 (includes a general physician exam, immunization, nutritional assessment and dental services).

Optional services, provided in some States but not others, include:

- screening and assessments
- preventive health services
- diagnostic services
- drugs
- eye glasses
- dental care for adults

Each State determines its own scope of services and limitations on those services. For instance, a State can set the number of reimbursable physician visits and the number of in-hospital days covered by Medicaid.

While fee-for-service is the dominant way of reimbursing health providers, some States use Medicaid funds to purchase services on a prospective basis. In other words, a State can sign a contract with a Health Maintenance Organization or Community Health Center and provide an up-front payment for which the facility agrees to provide all required services. The State of Florida signed such a contract with HMOs in Miami to provide medical services to Cuban entrants after the Mariel boat lift.

Although Medicaid is most widely used to pay for follow-up treatment for income eligible refugees, some public/private and private mechanism are also used. The Matching Grant program is the primary means of funding medical care through a combination of public and private monies. Under this program, Federal funds (of up to \$1,000 per refugee) are provided on a dollar-for-dollar matching basis to those national voluntary agencies which participate in the resettlement of non-Cuban, non-Southeast Asian refugees. Designed to provide an alternative to State-administered programs, the matching grants are

used to provide the same range of services, including cash and medical assistance and social services.

The matching grant voluntary agencies follow a number of different routes in providing medical assistance to the refugees that they resettle under this auspice.* Although some routinely enrolled their clients in Medicaid, others have attempted to provide alternatives. According to a recent report on the program, "methods of medical assistance provision include (1) donated care through outpatient divisions of hospitals, (2) donated or discounted services from physicians and dentists, and (3) direct payments for service by the agency." When serious conditions are present, hospitalization is required, or refugees remain unemployed for extended periods, clients are generally referred to Medicaid, since the matching grants and donated services do not adequately cover such expenses.**

Refugees not covered under Medicaid (because they are time-expired or exceed income requirements) or the Matching Grant program must usually find their own form of health coverage. Since many of the jobs in which refugees find employment do not offer health insurance to employees, refugees may find difficulty in purchasing this type of protection. One voluntary agency, Lutheran Immigration and Refugee Services (LIRS) implemented and financed through its own resources, a program aimed at alleviating this problem.

*Not all voluntary agencies are required to provide Medical Assistance as part of the matching grant agreement. For example, it is not included in ACNS' agreement.

**In Washington, D.C., according to this report, refugees could not be placed on Medicaid because income support from the Jewish Federation exceeded eligibility standards. Direct payments for hospital use was reported as a severe financial strain on the agency's resources. Lewin and Associates Inc., Voluntary Agencies and the ORR Matching Grant Program: Local Implementation Task II Report, May 1982.

Since 1973, LIRS has offered its non-Indochinese refugees* a group health insurance policy that provides limited coverage for accidents and new illnesses. Pre-existing illnesses are not covered. The agency loans money to the refugee to pay for this policy; the money is paid back on a scale consistent with the refugee's financial ability. Currently, the premium is \$136 per family and \$82.50 per individual for a six month period. Groups as varied as Ugandans, Kurds, Chileans and Ethiopians have taken advantage of this health insurance option.

*LIRS priced a health insurance policy for its Indochinese refugees, but the agency found that coverage of pre-existing illnesses (which seemed essential for this group) was too expensive for it to undertake.

CONTINUING CONCERNS ABOUT DOMESTIC REFUGEE HEALTH ISSUES

Three major areas of concern have been raised about the system through which the U.S. deals with refugee health problems that impede self-sufficiency:

- the timeframes within which health services are provided;
- the appropriateness of refugee services; and
- the use of Medicaid as the primary vehicle for providing health services.

In contrast to the discussion of public health concerns, critiques of the domestic system have been less focused and less likely to present specific evidence of problems. Rather, they have concerned themselves with broad questions regarding the adequacy of the program.

Timeliness

Certain obstacles to the timely delivery of health services to refugees have been identified. Although improvements have occurred in the programs aimed at linking refugees to a health care system, resettlement workers have noted difficulties in arranging for immediate follow-up treatment of conditions that are identified at health assessments. The major obstacle here is in the Medicaid system. Delays of 45 to 60 days in determining Medicaid eligibility are not uncommon. Although health providers are entitled to retroactive reimbursement for health services given to those later judged eligible, they are often reluctant to treat new arrivals who have not yet been issued Medicaid authorization. As a result of the delays in determining eligibility, refugees may not receive medical care during the initial stage of resettlement.

To prevent such delays, a policy of presumptive or initial eligibility has been proposed. Proponents recommend that refugees be deemed eligible for Medicaid immediately upon their arrival. They note that PHS has estimated that 90 percent or more of newly arrived refugees do qualify for the program. Thus,

they argue, the concept of presumptive or initial eligibility would not bestow a special benefit upon these individuals, but it would eliminate the delays in receiving care.

The recommended period during which the presumption of eligibility would hold varies. Most voluntary agencies, State refugee coordinators and service providers recommend that eligibility be granted for a one-year period, but some have stated that a six-month period would be acceptable to them. Some federal officials have recommended that the presumptive eligibility be continued only as long as it takes to make an actual determination of eligibility. Should a refugee be found ineligible, he or she would be removed from the program.

Opponents of presumptive eligibility argue that the program would give refugees benefits that are not available to other U.S. residents. Although the majority of refugees may be qualified for Medicaid, they argue, it is unfair to permit them automatic eligibility and immediate access to services when other Medicaid recipients must await determinations of eligibility. These opponents also stated that presumptive eligibility could result in increased federal expenditures on refugees. While proponents suggest that savings will accrue because refugees will more quickly become employable if their health needs are addressed, these claims have not been adequately documented.

Although most of the controversy about the timeliness of services has focused upon the initial period of resettlement, concerns have been voiced about the more general issue as to when services should be made available to refugees. Little is known about the health status of refugees at different points during their resettlement experience. For example, it is unknown if

initial health problems do impede self-sufficiency and if refugee continue to suffer from refugee-related illnesses after they have been in the country for 6 months, 12 months, 18 months or 36 months--although each of these times has been recommended as the length of eligibility for special medical assistance.

Related to this issue are concerns regarding the availability of health services for refugees who are no longer time-eligible for federally reimbursed programs. Many refugees--particularly those in entry-level jobs--do not have medical insurance coverage, even after they have been in the U.S. for 18 months. Critics argue that little attention has been paid to devising alternative programs to assist these refugees in meeting any continuing health needs. Part of the problem here lies in questions regarding the appropriate boundaries of federal responsibility. The lack of information about the health status of refugees further compounds it. Critics recognize that addressing this issue may not be the responsibility of governmental units, but, they argue, it still calls for consideration.

Appropriateness

The availability of appropriate services is a second concern of critics of the health care system. As noted above, each State determines the scope of medical services reimbursable under Medicaid, within guidelines set by the federal government regarding the provision of mandatory services. Many of those services most relevant to the needs of refugees are not covered in States with high concentrations of refugees. Among these are: diagnostic services, preventive services, dental services and prescribed drugs. Although some of the need for diagnostic services has been filled by the CDC grant program for health screenings and assessments, gaps still exist in the availability of these and other services.

Recent trends in Medicaid indicate that coverage of optional services is likely to decrease in the near future. In order to counter the effects of funding cutbacks in Medicaid, States are taking steps to limit access of Medicaid clients to some services and reduce the level of reimbursement for others. Many private health providers, faced with the reduction in coverage, are declining to treat Medicaid patients.

At the same time that these cutbacks have taken effect, there has also been a reduction in the level of funding for support services. Many States are giving primary consideration to the funding of employment services and language training, and they are reducing their commitment to providing health and mental health related services. As a result, many programs to provide translators, transportation, counseling, day care and similar services have ended. Those arguing that these cut backs are justified suggest that the need for some of these services has diminished with the development of a more established refugee community. Nevertheless, according to others, the effectiveness of a medical system for refugees is often determined by the availability of professional services designed to increase access and provide a culturally appropriate setting. They argue that the refugee community will be unable to fill all of the gaps caused by the change in funding priorities.

Reductions in the funding of mental health services have occurred. In previous years, mental health projects were awarded grants from the federal government. The purpose of these programs was described as follows: "To bridge the gap between existing mental health facilities and services and the needs of the refugee community." Beginning in FY 1980, funding for such projects was funneled through social services monies.

With the recent emphasis on limiting funding to employment services and English training, though, these services have lost support. Yet, mental health problems are surfacing as those in their second and third year of resettlement begin to reflect on their previous experiences and seek assistance in dealing with the trauma of resettlement.

Some espouse that, should the recent trends in both Medicaid and social service funding continue, the development of alternative mechanisms for financing appropriate services will need to be considered.

Use of the Medicaid Financing Mechanism and Refugee Dependency

Reliance on the Medicaid system for financing health services for refugees has raised a fundamental issue regarding the relationship between medical and cash assistance. A principal concern of groups that work with refugees is the claim that use of Medicaid has led to an undue dependency on the overall welfare system.

In the majority of States, eligibility for Medicaid is tied directly to income eligibility for cash assistance. In other words, to qualify for Medicaid, an individual must demonstrate that his or her income falls below the level established for other welfare programs (in some States, an individual's income level can exceed these standards and receive Medicaid if that person's medical expenses reduce his or her income to AFDC levels. The federal government has established similar "spend-down" requirements for refugees who apply for the fully ORR-funded Refugee Medical Assistance Program.) In some States, the link goes further--eligibility for Medicaid is tied to receipt of welfare benefits. In these States, an employed individual whose earnings fall below the income eligibility requirement for welfare, but chooses to continue to work, will not qualify for Medicaid.

According to many resettlement experts, the tie between eligibility requirements for cash and medical assistance reduces the incentive to take jobs because health coverage is unavailable and acceptance of the position would eliminate their eligibility for medicaid. A Principal Regional Official of HHS described this problem in a 1979 letter to ORR:

To a great extent, medical eligibility is ancillary to cash benefits. Refugee heads of households often apply for cash assistance to obtain medical coverage for dependents.

Because of this system, critics of Medicaid argue, dependency is encouraged and self-sufficiency is impeded.

Even in States in which receipt of Medicaid is not tied to receipt of cash assistance, the administration of the two programs is linked. Applications for Medicaid are taken in the same offices as applications for welfare. Often, during the course of applying for Medicaid, refugees learn of the range of other assistance programs available to them. While few would argue that such information be kept from individuals who are legally eligible for such benefits, critics point out that this system nevertheless encourages dependency.

Calls for the separation of cash and medical assistance have become commonplace--from researchers, resettlement workers and government officials. In 1979, Taft, Ford and North, in their seminal study "Refugee Resettlement in the United States: Time for a New Focus," recommended such a change in the system through which health coverage is provided to refugees. Similarly, a 1980 ORR medical assistance policy option paper recommended that "all refugees be granted a period of eligibility for health assistance without requiring an application." Among written comments to the department on this issue was one from the Director of the PHS Office of Refugee Health Affairs, supporting a six month period of automatic eligibility for medical assistance. This

decision, he commented, was based on prior experience treating the health problems of Indochinese refugees, which were best handled in a timely fashion.

The Final Report of the Select Commission on Immigration and Refugee Policy also recommended that "medical assistance for refugees should be more effectively separated from cash assistance programs." Dr. Barry Stein, in a paper submitted to the Select Commission, suggested that refugees receive automatic eligibility for one year; another contributor, Dr. Norman Zucker, called for a change in current policy to render medical assistance unconditional on welfare eligibility for a set period of time. The voluntary resettlement agencies also called for separation in testimony before the Commission; Wells Klein, Executive Director of the American Council for Nationalities Service, noted that "the new legislation (i.e., the Refugee Act of 1980), mandates the availability of Medicaid separate from cash assistance for one year."

Following an investigative trip to Southern California in the fall of 1981, the House Subcommittee on Immigration, Refugees and International Law recommended that "the Department of Health and Human Services should utilize the authority granted in the Refugee Act to separate eligibility for medical care from cash assistance for refugees who are in the U.S. for less than one year." The HHS Special Report to Congress on Refugee Resettlement also proposed investigating the possibility of uncoupling the two programs, citing the lack of incentives for promoting self-sufficiency under the present administration of the cash and medical assistance program.

Separation has not received universal acceptance. The National Association of Counties, for example, has based its opposition on the following factors:

First, they claim, linkage of cash and medical assistance is not a significant factor affecting dependency in refugees. Instead, NACo reports, indigent refugees apply for public assistance because they do not receive sufficient support from sponsors and they are usually unemployed.

Second, they note, separation would result in excessive costs because greater numbers of refugees would be covered by the program and new bureaucratic structures would be needed to administer it.

Finally, they argue, equity questions are raised if refugees are offered a special medical assistance program not available to other poor or otherwise disadvantaged groups. The disincentives to employment apply to other populations that are reluctant to accept jobs because of the loss of medical benefits.

(This argument has been countered by proponents of separation who argue that the U.S. should not repeat mistakes it has made with other groups when dealing with refugees.)

Significantly, neither the advocates nor the opponents of separation of cash and medical assistance have special expertise in addressing health financing issues. Generally, recommendation for change have not been accompanied by a thorough exploration of the steps needed to achieve this goal. Options, ranging from conversion to a system of government-subsidized health insurance to the provision of automatic eligibility for Medicaid, have been suggested. But, they have not been adequately assessed, in the opinion of those responsible for policy making, to determine their technical and political feasibility, cost, equity vis a vis programs for other needy populations, or likely implications in terms of refugee adjustment.

Nor is it clear under what authority a change in policy should be pursued. Most proponents of a separation cite the language in the Refugee Act that permits the Director of ORR to make special provisions for medical assistance for those refugees who, during their first year in this country, do not qualify for a State Title XIX program. This section of the Act further requires that in such a program a refugee be required to meet alternative financial resources and income requirements as established by ORR. Automatic eligibility for

Medicaid -- i.e., eligibility without regard to income -- would, it appears, be precluded under this provision. Even if a very high level of income were set as the threshold for receiving benefits, procedures for determining eligibility would still be needed and delays, similar to those found in the current system, could result.

A close reading of the Refugee Act indicates that change could be accomplished under other clauses that permit greater flexibility. The Act states that the federal government will reimburse public or private agencies furnishing medical assistance to refugees for up to the first 36 months a refugee in this country. The Refugee Act does not specify that medical assistance will be provided under Title XIX, nor does it limit reimbursement to State governments. (The Matching Grant program is an example of federal grants to private agencies for the purpose of funding medical assistance.) Further examination of actions permissible under the more flexible clauses would, therefore, be appropriate.

CONCLUSIONS

Two perceptions have been influential in forming the boundaries of the debate on medical assistance: that refugees are not receiving timely and appropriate services to meet their special health needs, and that reliance on the Medicaid system has contributed to longer term dependency on public assistance than would be the case with alternative approaches.

These assertions have not been accompanied by sufficient documentation to prove their validity. For example, little is known about the extent to which specific refugee health problems impede self-sufficiency. Even less is known about the health status of refugees at different points in their resettlement experiences. Anecdotal evidence abounds -- from sponsors and resettlement workers -- that health problems retard the progress of refugees toward self-sufficiency, but there is little data to support this perception. A basic question remains unanswered: Is there need for a special program (that is, one separate from Medicaid) designed to remove health barriers to employment--and, if so, for how long?

Even accepting the need for special programs for medical assistance (or recognizing that an important purpose of the program is to alleviate financial burdens on States and localities--thus necessitating a program regardless of refugee needs), insufficient thought has been given to the design and implications of proposed changes. All too often in the refugee program, change is sought without careful examination and understanding of the feasibility of the action. In the case of separation of cash and medical assistance, options for a totally new health care delivery system -- generally through private agencies--have been presented without adequate supporting materials regarding their cost, technical feasibility, relationships to

programs for other populations, ramifications for refugee resettlement, or political feasibility. Development of such substantiating evidence is required if the proposed alternate approaches are to be advanced.

Further, sufficient exploration of the flexibility inherent in mechanisms already in use has not occurred. The Medicaid system, even with all its weaknesses, provides a solid core of services to needy populations. Modifications in the existing Medicaid plan need to be considered before a determination is made to convert to a different system.

In sum, in order to address the issue of health care for refugees, there needs to be a better understanding of the problem, clarification of goals, analysis of alternatives and discussion of the implications of proposed changes. It is hoped that this paper -- by describing current policies, programs and concerns -- will provide a context for advancing this process.

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